

RE-ENROLL _____

ADD _____



CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

520 E. Herndon Avenue Fresno, CA 93720 559-437-2960 Fax 559-437-2965 800-288-9870 www.cvtrust.org

EXTENDED DEPENDANT CERTIFICATION REQUEST PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

SUBSCRIBER'S NAME AND ADDRESS (<input type="checkbox"/> Check if New Address)	
SUBSCRIBER'S SOCIAL SECURITY #	SUBSCRIBER'S EMPLOYER

DEPENDANT MEANS EMPLOYEE'S UNMARRIED NATURAL, ADOPTED, OR STEPCHILD, AGE 19 TO 25, WHO MEETS **ONE** OF THE FOLLOWING CONDITIONS:

1. IS ENROLLED AS A REGULAR FULL-TIME (12 UNITS OR MORE) STUDENT AT AN ACCREDITED INSTITUTE. **(PROOF OF REGISTRATION INDICATING UNITS NEEDS TO BE ATTACHED.)**
2. IS CLAIMED AS A DEPENDANT ON THE EMPLOYEES FEDERAL INCOME TAX RETURN. **(A COPY OF PAGE 1 OF FORM 1040 NEEDS TO BE ATTACHED.)**

ABOVE REQUESTED DOCUMENTATION NEEDS TO BE ATTACHED AND RECEIVED WITHIN 31 DAYS OF THE NEW PERIOD OF ELIGIBILITY.

Dependant's Name (Last, First, Middle)		
Dependant's Marital Status:	Dependant's Gender:	Dependant's Birthdate: _____
<input type="checkbox"/> Single	<input type="checkbox"/> Male	Dependant's SS#: _____
<input type="checkbox"/> Married	<input type="checkbox"/> Female	
My son/daughter was listed as a dependant on my last tax return <input type="checkbox"/> Yes <input type="checkbox"/> No		
I anticipate claiming my son/daughter as a dependant on my next Federal Tax Return:		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

I agree to notify California's Valued Trust within 30 days of any change in this dependant's eligibility, including enrollment in less than 12 units, marriage, or loss of IRS dependant status. I will be responsible to reimburse any claim payment made on behalf of non-eligible dependants.

SUBSCRIBER'S SIGNATURE

DATE SIGNED